

Hot Topic

Caring for Suicidal Patients

The ethical treatment and handling of suicidal patients are challenging topics that many of us have faced. It raises a question that seems counterintuitive: How are we to properly respect a person's choices if those choices involve harming oneself?

Say a patient presents in the emergency department after a suicide attempt. How should you treat this patient? If you do not aggressively respond, are you a participant in causing that person's death? What if that patient was accompanied by a documented, valid Do Not Resuscitate Order? These questions leave clinicians in a difficult position of discerning between the duty to respect the patient's wishes (the principle of respect for autonomy) and obligation to do good (the principle of beneficence).

Three Responsibilities

There are at least three clinical responsibilities that apply to this situation:

1. "Aggressively treat the immediately life-threatening consequences of a suicide attempt, regardless of the patient's wishes;"
2. "Honor the clearly expressed and verifiable preference of patients who do not wish to be resuscitated;" and
3. "If there is doubt regarding the patient's wishes or the validity of a document, initiate resuscitative efforts"

([Heinrich, Morgan, & Rottman, 2011, p. 194](#)).

The clinician's ethical obligation to care for the patient is not suspended because of a patient's willful action in precipitating the reason for treatment. This obligation remains even with attempted suicide. Probate Code even in California, a state that legalized physician aid in dying (physician assisted death) in 2015, states:

"Nothing in this division shall be construed to condone, authorize, or approve mercy killing, assisted suicide, or euthanasia. This division is not intended to permit any affirmative or deliberate act or omission to end life other than withholding or withdrawing health care pursuant to an advance health care directive, by a surrogate, or as otherwise provided, so as to permit the natural process of dying" ([California Probate Code 4653](#)).

Current ER Standards

Because suicide is not a "natural process" of dying, a provider would likely be in violation of this Probate Code if care were withheld. Depending upon the condition of the patient at the time of the suicide attempt, the interpretation of the word "natural" may be debated. In any event, Heinrich, Morgan, & Rottman (2011) argue that, "in cases of physically healthy patients who attempt preemptive suicide or patients with diagnosed mental illness, emergency physicians should not recognize the validity of advance directive, or a patient's previously expressed preferences to forego life sustaining treatment" (p. 195). They further argue that to abandon current emergency department standards would negatively serve the vast majority of patients whose attempted suicide failed and upon surviving were thankful for receiving treatment" ([op.cit, p. 195](#)).

Interestingly, many patients whose attempt at suicide fails do not ultimately die of suicide. [A study following 515 people](#) prevented from jumping off the Golden Gate Bridge between 1937 and 1971 found after 26 years, that 94% were still alive or had died of natural causes. Another study conducted by Suominen et al. (2004), which followed persons attempting suicide by poisoning, found 87% alive or dying of natural causes after 37 years ([Suominen et](#)

[al., 2004](#)). In 2002, a meta study looking at attempts that led to hospitalization found that 93% did not die of suicide ultimately. Clearly from these studies, there is substantial evidence pointing to the long term benefits of treating a patient following a suicide attempt ([Owens et al, 2002](#)).

Two Situations, Two Processes

So, what should guide a clinician's response in these situations? Depending upon patient capacity, two courses of action can serve the clinician.

For those patients with capacity, the adoption of the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) model is recommended. This assessment tool "guides a provider through a stepwise evaluation of a patient's risk and protective factors and the specifics of the suicidal thoughts or plans to estimate overall risk ([Betz & Boudreaux, 2016, p. 278-279](#)). The steps being:

1. Identify risk factors
2. Identify protective factors
3. Conduct suicide inquiry
4. Determine risk level and intervention, and
5. Document

If the patient does not have capacity, [Casey Frank \(2013\)](#) says: "The reconciliation of autonomy and protective beneficence is achieved starting with the crucial initial treatment: a liberal dose of the tincture of time" (p. 100). This waiting may take several forms and will require patience but giving time to properly address the difficulties of the situation is necessary.

These are challenging recommendations for complex situations. Individuals who attempt suicide are vulnerable people who continue to deserve our respect and care. No easy or perfect solutions exist, but as health care providers, we are always bound by the duty of care.

Bioethics in the News

[Medical ethics' is ethics by, for and about medics, not common morality](#)

[Why bioethics around artificial reproductive technology are not just women's issues](#)

[Moral distress and moral strength among clinicians in health care systems](#)

[As Made-To-Order DNA Gets Cheaper, Keeping It Out Of The Wrong Hands Gets Harder](#)

Case Study

"Give me something. I want to die.": The Case of Joe

Tarris Rosell, PhD, DMin

"Joe" is a 62 year old building contractor who has been in an ICU for the past 10 weeks. He had gone to his community hospital for bypass surgery (CABG) and aortic valve repair (AVR), and things didn't go well post-op. His sternal wound became infected with Methicillin-resistant Staphylococcus aureus (MRSA). Sepsis led to acute hypoxic respiratory failure, a tracheotomy, profound hearing loss, and then acute renal failure ameliorated somewhat by hemodialysis. Per chart notes, he is not improving sufficiently to warrant hope for recovery. The best that can be hoped for now, says his critical care physician, is discharge to a long-term acute care hospital (L-TACH). The prognosis does not include any likelihood of return to baseline, or to home. The situation is dire, and Joe seems to "get it".

On Saturday, he mouths a message to his nurse, and then to the physician who is summoned, and then to an ethics consultant also. "Stop everything. Give me something. I want to die." Joe repeats his request with family at the bedside. In later conversation with the ethics consultant, they express frustration with Joe for wanting to "quit". "That's not Joe. He's stubborn. Never quits. He's been through worse than this, and then went back to work. He must be depressed or not thinking clearly now."

Joe is deemed to have decisional capacity, per Psychiatry consult. He has been informed already that, "We can't give you something to die. That's not legal, not in this state." Although that answer seems to frustrate Joe, he continues to ask that "everything stop." No more aggressive treatment. Stop the antibiotics. No more vent. "I want to die." The wife, a sister and two adult children--one of them a nurse in our facility—believe he does not have capacity and is only speaking from depression.

Discussion questions:

1. Is he depressed and not thinking clearly?
2. What now should be done for Joe--and his family?
3. Ethical Musings

Ethical Musings

Suicide: A Philosophical Conundrum

There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy. All the rest — whether or not the world has three dimensions, whether the mind has nine or twelve categories — comes afterwards (The Myth of Sisyphus), writes French Algerian philosopher Albert Camus. The conscious decision of a person, self, mind, etc. to choose to no longer exist has fascinated many over the years. Why would someone actively choose such an act? But suicide is more than just a philosophical exercise or thought experiment; it is a real human tragedy that leaves its pain and suffering on the world well after the individual who commits the act has left it.

Who Owns a Life?

What is the moral permissibility of suicide? The central question of the ethics of suicide regards the individual's assessment of owning one's life. Classical liberalism has stressed the importance of individual freedom. If one is truly the sole owner of her life, then one should be free to do with said life what one wishes. This sense of sole ownership of life has, for some, become a foundational tenet of modern western medical decision making supported by the ethical principle of autonomy. Losing a sense of autonomy/freedom can be a severe challenge for many people in maintaining a sense of identity and notion of one's purpose for being in the world. Since 2016, participants seeking physician aid in dying in the State of Washington ([Washington Death with Dignity Act](#)) report loss of autonomy as the number one concern, with 85% in 2018, 90% in 2017, and 87% in 2016. This ranked higher than participants being able to engage in activities making life enjoyable, loss of dignity, and pain control. This loss of control/autonomy, brought about by illness, leads many to determine their experience of a diminished quality of life. But how can we overcome this mental distress when death and illness are so natural? One way may be through strengthening our connections to others.

In a recent poem in The New Yorker, poet D.A. Powell writes, "Your life is not your own and never was..." ([Open Gesture of an I](#)). While the sense of autonomy is important for many, to others life is a shared event. We share it with those around us, we share it with our loved ones, we share it with our communities, we share it with a universal higher power. Our lives are not our own, therefore, we have no ethical right to end them prematurely.

Ethics of Care

The Ethics of Care, is an ethical theory developed, in part, by the work of Carol Gilligan. Gilligan posits that the relationships we create and maintain hold special importance. The idea of Care Ethics is born out of our “motivation to care for those who are dependent and vulnerable, and it is inspired by both memories of being cared for and the idealizations of self...”. Centrally, it “affirms the importance of caring motivation, emotion and the body in moral deliberation, as well as reasoning from particulars” ([The Internet Encyclopedia of Philosophy \(IEP\)](#)). Those suffering from suicidal ideation are dependent and vulnerable, and therefore require our care.

Camus reached the conclusion that one should not commit suicide, even if life is absurd. He argued that suicide is the false promise of freedom and, rather, that we should strive to overcome the absurdity by confronting the difficulties of life directly. In doing so, meaning in life deepens.

Ryan Pferdehirt